



The Hilltop Institute

analysis to advance the health of vulnerable populations

Continuity of Care Analysis

October 15, 2012

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CoC Advisory Committee Meeting

Presentation Goals

- Review examples of continuity of care/transition plan provisions
- Overview of analysis
- Obtain committee feedback on transition populations for analysis

Continuity/Transition Plan Examples

Examples of Transition Plans

- Maryland Medicaid
- Maryland commercial market

Maryland Medicaid

- Health risk assessment
- Self-referral

Health Risk Assessment

- Health risk assessments administered at the time of enrollment ask questions about health service needs
- Information is transmitted to the MCO, which uses the information to take appropriate action for new enrollees with special or immediate health needs

Health Risk Assessment Form



The Maryland Department of Health and Mental Hygiene

HEALTH SERVICE NEEDS INFORMATION

Please answer the questions below. This information will be given to your MCO. It will help your MCO decide how soon you may need to see a doctor or nurse and what health care services you may need.

Complete the information for yourself as Head of Household and each family member. After completion, return this form with your HealthChoice enrollment form to HealthChoice, P.O. Box 17008, Baltimore, MD 21203

Information about you and family members	Head of Household	Family Member 1	Family Member 2	Family Member 3**
Please write in today's date				
Please write in names				
Please write in Medical Assistance Numbers				
Health questions				
1. Are you (or a family member) taking any prescription medications that need to be refilled?	Within a week? <input type="checkbox"/> Yes <input type="checkbox"/> No Within 1 month? <input type="checkbox"/> Yes <input type="checkbox"/> No Within 2 months? <input type="checkbox"/> Yes <input type="checkbox"/> No	Within a week? <input type="checkbox"/> Yes <input type="checkbox"/> No Within 1 month? <input type="checkbox"/> Yes <input type="checkbox"/> No Within 2 months? <input type="checkbox"/> Yes <input type="checkbox"/> No	Within a week? <input type="checkbox"/> Yes <input type="checkbox"/> No Within 1 month? <input type="checkbox"/> Yes <input type="checkbox"/> No Within 2 months? <input type="checkbox"/> Yes <input type="checkbox"/> No	Within a week? <input type="checkbox"/> Yes <input type="checkbox"/> No Within 1 month? <input type="checkbox"/> Yes <input type="checkbox"/> No Within 2 months? <input type="checkbox"/> Yes <input type="checkbox"/> No
2. Are you (or a family member) using any medical equipment or supplies that need to be renewed?	Within a week? <input type="checkbox"/> Yes <input type="checkbox"/> No Within 1 month? <input type="checkbox"/> Yes <input type="checkbox"/> No Within 2 months? <input type="checkbox"/> Yes <input type="checkbox"/> No	Within a week? <input type="checkbox"/> Yes <input type="checkbox"/> No Within 1 month? <input type="checkbox"/> Yes <input type="checkbox"/> No Within 2 months? <input type="checkbox"/> Yes <input type="checkbox"/> No	Within a week? <input type="checkbox"/> Yes <input type="checkbox"/> No Within 1 month? <input type="checkbox"/> Yes <input type="checkbox"/> No Within 2 months? <input type="checkbox"/> Yes <input type="checkbox"/> No	Within a week? <input type="checkbox"/> Yes <input type="checkbox"/> No Within 1 month? <input type="checkbox"/> Yes <input type="checkbox"/> No Within 2 months? <input type="checkbox"/> Yes <input type="checkbox"/> No
3. Does a health care worker come to your house?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Are you (or a family member) getting counseling for any of the following:	Mental health? <input type="checkbox"/> Yes <input type="checkbox"/> No Alcohol use? <input type="checkbox"/> Yes <input type="checkbox"/> No Drug use? <input type="checkbox"/> Yes <input type="checkbox"/> No	Mental health? <input type="checkbox"/> Yes <input type="checkbox"/> No Alcohol use? <input type="checkbox"/> Yes <input type="checkbox"/> No Drug use? <input type="checkbox"/> Yes <input type="checkbox"/> No	Mental health? <input type="checkbox"/> Yes <input type="checkbox"/> No Alcohol use? <input type="checkbox"/> Yes <input type="checkbox"/> No Drug use? <input type="checkbox"/> Yes <input type="checkbox"/> No	Mental health? <input type="checkbox"/> Yes <input type="checkbox"/> No Alcohol use? <input type="checkbox"/> Yes <input type="checkbox"/> No Drug use? <input type="checkbox"/> Yes <input type="checkbox"/> No
5. a. Are you (or a family member) pregnant or have you (or a family member) had a baby in the past two months?	<input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, answer 5b and 5c.</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, answer 5b and 5c.</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, answer 5b and 5c.</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, answer 5b and 5c.</i>
b. If pregnant, how far along in months?	<input type="checkbox"/> 1-3 <input type="checkbox"/> 4-6 <input type="checkbox"/> 7-9	<input type="checkbox"/> 1-3 <input type="checkbox"/> 4-6 <input type="checkbox"/> 7-9	<input type="checkbox"/> 1-3 <input type="checkbox"/> 4-6 <input type="checkbox"/> 7-9	<input type="checkbox"/> 1-3 <input type="checkbox"/> 4-6 <input type="checkbox"/> 7-9
c. Are you (or a family member) seeing a doctor or nurse for this pregnancy? If yes, write in the doctor's or nurse's name.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

** If you need additional space for extra family members, please call the HealthChoice Enrollment Line at 1-800-977-7388

Health Risk Assessment Form

continued



The Maryland Department of Health and Mental Hygiene

HEALTH SERVICE NEEDS INFORMATION

Health questions	Head of Household	Family Member 1	Family Member 2	Family Member 3**
Please write in names				
6. Do you (or a family member) have any of the following health problem(s)? <i>Check all that apply.</i>	<input type="checkbox"/> Asthma <input type="checkbox"/> Cerebral palsy <input type="checkbox"/> Diabetes <input type="checkbox"/> Heart disease <input type="checkbox"/> High blood pressure <input type="checkbox"/> Sickle cell disease <input type="checkbox"/> Lead poisoning <input type="checkbox"/> Other _____	<input type="checkbox"/> Asthma <input type="checkbox"/> Cerebral palsy <input type="checkbox"/> Diabetes <input type="checkbox"/> Heart disease <input type="checkbox"/> High blood pressure <input type="checkbox"/> Sickle cell disease <input type="checkbox"/> Lead poisoning <input type="checkbox"/> Other _____	<input type="checkbox"/> Asthma <input type="checkbox"/> Cerebral palsy <input type="checkbox"/> Diabetes <input type="checkbox"/> Heart disease <input type="checkbox"/> High blood pressure <input type="checkbox"/> Sickle cell disease <input type="checkbox"/> Lead poisoning <input type="checkbox"/> Other _____	<input type="checkbox"/> Asthma <input type="checkbox"/> Cerebral palsy <input type="checkbox"/> Diabetes <input type="checkbox"/> Heart disease <input type="checkbox"/> High blood pressure <input type="checkbox"/> Sickle cell disease <input type="checkbox"/> Lead poisoning <input type="checkbox"/> Other _____
7. Have you (or a family member) been seeing or are scheduled to see a doctor, nurse or visit a clinic? If yes, please write in the name of the doctor, nurse or clinic.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
8. Members of certain groups need special services. Are you (or a family member) a member of any of the special needs groups listed below:				
a. A child with a special health care need? If yes, please explain the special need.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
b. Have a developmental delay?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
c. Homeless?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
d. Have a physical disability?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
e. Have HIV/AIDS?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
9. If you (or a family member) are between the ages of 2 and 21, when did you last see a dentist?	<input type="checkbox"/> Less than 6 months ago <input type="checkbox"/> 6 – 12 months ago <input type="checkbox"/> 12 months or more	<input type="checkbox"/> Less than 6 months ago <input type="checkbox"/> 6 – 12 months ago <input type="checkbox"/> 12 months or more	<input type="checkbox"/> Less than 6 months ago <input type="checkbox"/> 6 – 12 months ago <input type="checkbox"/> 12 months or more	<input type="checkbox"/> Less than 6 months ago <input type="checkbox"/> 6 – 12 months ago <input type="checkbox"/> 12 months or more

DE0014

Self-Referral

- Enrollees may self-refer for certain services from out-of-network providers:
 - Family planning
 - School-based health center
 - Pregnancy-related services initiated prior to enrollment
 - Initial medical exams for children in state custody
 - One annual diagnostic & evaluation visit for enrollees living with HIV/AIDS
 - Renal dialysis in a Medicare-certified facility
 - An initial medical exam for a newborn in the hospital
 - Substance abuse treatment services
 - Emergency services

Self-Referral continued

- MCO must reimburse the out-of-network provider at the Medicaid rate

Maryland Commercial Market

- Maryland insurance code
- National Committee for Quality Assurance (NCQA) standards
- Example CareFirst policy

Maryland Insurance Code

- Continuation of coverage for surviving spouses/dependent children; divorced spouses/dependent children; and involuntarily terminated employees (MD Insurance Code Ann. §15-407-409)
- Extension of benefits (MD Insurance Code Ann. §15-833): Requires certain health plans to
 - Pay covered benefits for individuals who are **totally disabled** when the coverage terminates up to the lesser of 12 months or the date the individual ceases to be totally disabled
 - Pay a **claim in progress** on the date coverage terminates up to the lesser of the release from care from the physician or 12 months

Maryland Insurance Code

continued

- Extension of benefits ...
 - Pay covered benefits for individuals confined in a **hospital** on the date coverage terminates up to the lesser of the discharge date or 12 months
 - Provide covered **vision benefits** if contacts/glasses ordered prior to the termination date, if the individual receives the glasses/lenses within 30 days
 - Provide covered **dental benefits** for a course of treatment for at least 90 days after termination if the treatment began before the termination date and requires two or more separate visits

NCQA Continuity & Coordination Standards

- Applies to NCQA-accredited commercial health plans and requires:
 - Collection of data and analysis to identify and prioritize opportunities to improve coordination of medical care
 - Annual action to improve coordination on at least two of the opportunities identified
 - Notification of members affected by the termination of a practitioner or a practice group in general, family, and internal medicine, at least 30 days prior to termination, and helps select a new practitioner

NCQA continued

- If a practitioner's contract is discontinued, continuation of treatment through current period of active treatment for chronic or acute medical condition for up to 90 days; or continuation through postpartum period for members in 2nd or 3rd trimester
- Help a member transition to other care, if necessary, when benefits end, including offering to educate members about alternatives for continuing care and how to obtain care if the covered benefits are exhausted while a member still needs care

Example: CareFirst Transition of Care Program

- Allows members/covered dependents to request to continue to receive care from an out-of-network physician for up to 90 days following the date of enrollment (benefits paid at in-network level)
- Applies to certain unstable and serious medical conditions that require a limited course of treatment or follow-up care

Example: CareFirst

Transition of Care Program

continued

- Examples of conditions that may qualify:
 - Pregnancy (beyond 24 weeks)
 - Bone fractures
 - Recent heart attack
 - Other acute trauma or surgery
 - Joint replacement
 - Newly diagnosed cancer

Overview of Analysis

What is “Churn”?

- “Frequent movement between Medicaid and state-run health insurance Exchanges”
- National estimates project that 35% of adults <200% of the FPL will shift between Medicaid and Exchange eligibility within a 6-month time period
- Need for Maryland-specific estimates

Sources:

Hwang, A., Rosenbaum, S., & Sommers, B. (2012). Creation of State Basic Health Programs. *Health Affairs*. 31, no. 6: 1314-1320

Ingram, C., McMahon, S., & Guerra, V. (2012, April). Creating Seamless Coverage Transitions between Medicaid and the Exchanges. State Health Reform Assistance Network Issue Brief.

Estimation of Churn in Maryland

- Estimate the rate of turnover in Medicaid eligibility
 - Identify Medicaid beneficiaries who lost eligibility or were newly enrolled in 2011
- Separate by Medicaid eligibility categories

Cost Estimation

- Identify Medicaid claims history for churn population
- Identify health care services provided in the months prior to loss of eligibility and post new enrollment
- Estimate cost of services for each individual
- Contract actuary will estimate impact of several transition plan options on premiums

Transition Populations for Analysis

Committee Feedback

Transition Populations	Committee Comments
1. Pregnancy	
2. Hospitalizations occurring during the termination date	
3. Chronic treatment conditions:	
Chemotherapy	
Radiation	
Dialysis	
4. Organ transplant care	
5. Individuals demonstrating ongoing care needs	
Durable medical equipment	
Home health	
Prescription medications for management of chronic care conditions	
6. Individuals with approved prior authorization for procedures	
7. Behavioral health and chemical dependency	
8. Other?	

About The Hilltop Institute

The Hilltop Institute at UMBC is a non-partisan health research organization—with an expertise in Medicaid and in improving publicly financed health care systems—dedicated to advancing the health and wellbeing of vulnerable populations. Hilltop conducts research, analysis, and evaluations on behalf of government agencies, foundations, and nonprofit organizations at the national, state, and local levels. Hilltop is committed to addressing complex issues through informed, objective, and innovative research and analysis.

www.hilltopinstitute.org

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